THE TREATMENT OF THE ADDICT IN BRITAIN*

EDWIN M. SCHUR, PH.D.

Assistant Professor of Sociology
Tufts University, Medford, Massachusetts

IT is understandable that the medical practitioner tends to see the problem of narcotic addiction as primarily involving the treatment of individual addict patients. At the same time, however, those professionally concerned with addiction have a responsibility to interest themselves in the relevant public policy measures, for these measures, after all, establish the context within which any treatment efforts must operate. From this standpoint the differences between the American and the British policies toward addiction—my detailed studies of which have been presented elsewhere[1]—may assume considerable importance. The crucial contrast between the two approaches relates to the overall view of the addict and to the role of the medical profession in the management and treatment of addiction.

Jeffrey Bishop, a British physician, succinctly summarized the British addict's position as follows. He wrote: "To be a drug addict has never been and is not now illegal in this country. The addict is committing an offense only if drugs found in his posssession have been unlawfully obtained. He is regarded as a sick person in need of medical care, and not as a criminal to be hounded by the police."[2] Under the Dangerous Drugs Act persons authorized to handle opiates, and certain other drugs, must keep careful records of drugs received and supplied. These records are periodically examined by the Home Office and special Ministry of Health inspectors. Doctors who improperly divert supplies to their own use, or who otherwise violate the drug laws, are subject to fine or imprisonment and may also lose their right to possess and prescribe such drugs.

Within broad limits, however, the British doctor has almost complete professional autonomy in reaching decisions about the treatment

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of addiction. Official policy permits prescription of opiates to addicts in connection with gradual withdrawal treatment, where severe withdrawal symptoms make a cure medically inadvisable, or where regular small doses afford the addict a fairly normal existence which he could not otherwise achieve.[3] While doctors are warned against prescribing drugs for "the mere gratification of addiction", the decision as to when an addict is in need of drugs remains a medical one. As the Home Office has stated in an official report on addiction: "In the United Kingdom the treatment of a patient is considered to be a matter for the doctor concerned. The nature of the treatment given varies with the circumstances of each case."[4] The term "treatment" is, in fact, interpreted very broadly, to include long-term prescription of narcotics where that is felt necessary and such treatment may be on an ambulatory basis. I have recently heard a London psychiatrist, Lady Isabella Frankau, describe the procedure she has followed in treating addicts, and I was most impressed by her discussion of the way in which controlled medical prescription of drugs can significantly facilitate efforts at intensive and prolonged psychotherapy with addict patients.

Doctors are requested but not required to inform the Home Office of any addicts who come under their care. There is no provision for compulsory withdrawal treatment of addicts, and there are no special facilities for treatment of addiction. In 1961, an interdepartmental committee appointed to survey the entire addiction situation in Great Britain and chaired by Sir Russell Brain, issued its report[5] which indicated general satisfaction with the existing practices and regulations. The committee specifically denied the advisability of compulsory committal or required registration of addicts, or of the establishment of specialized treatment institutions. It also stated that: "Irregularities in prescribing of dangerous drugs are infrequent and would not justify further statutory controls." Attorney Rufus King has aptly characterized the British situation by stating: "The British medical profession is in full and virtually unchallenged control of the distribution of drugs, and this includes distribution by prescription or administration to addicts when necessary. The police function is to aid and protect medical control, rather than to substitute for it."[6]

Some British doctors have diverted drugs to their own use—as has occurred in the United States also—and there have been occasional

minor drug violations by addicts; for example, forging a prescription to get a little more drug than the doctor prescribed. But these lapses are quite uncommon, and generally, as you may know, the addiction situation in Great Britain has, under this medically oriented policy, remained remarkably benign.[1] There are only about 500 opiate addicts in the United Kingdom. Practically no serious crimes are committed by addicts, there is hardly any illicit traffic in opiates, and opiate addiction has not significantly spread to juveniles. These conditions, of course, contrast sharply with those found in the United States, where among the most dangerous aspects of the narcotics problem have been the thriving black market, the prevalence of addict crime, and the high rate of drug use by juveniles.

Without doubt it would be a mistake to attribute these differences solely to the difference in public policy. At the same time, it seems impossible to deny the impact such policy has on the drug problem. In Britain, legal provision of low-cost drugs (and the addict qualifies as a patient under the National Health Service) drastically undercuts the profit incentives to illicit trafficking and eliminates, or at least largely eliminates, the addict's need to steal in order to support his habit.

In comparing the British and American experiences, one sees that certain aspects of addict behavior, which we in this country have tended to view as inevitable correlates of addiction, are in fact largely determined by the nature of the social reaction to the addict. In particular, addict crime and involvement in illicit traffic cannot be attributed directly either to the effects of the drugs in question or to the psychological characteristics of the individuals involved. We must keep in mind that the way addicts are dealt with does affect how they act and how they view themselves and their society. A human being addicted to narcotics does not, *ipso facto*, commit crimes, view himself as a criminal, or find his only comfort in a community of addicts. Must we not admit that by treating the addict as a criminal we have caused him to become one? I certainly do not intend to suggest that there are no primary behavioral correlates of the state of addiction. It appears that many of the addicts in Britain continue to be disturbed and, in some instances, relatively unproductive individuals but, unlike their American counterparts, they have not become social menaces and surely this is a noteworthy difference.

Comparing the British and American situations also serves to underline the role of supply and demand factors in shaping a country's addiction problem. Addiction may be seen as but one example of a more general category of social problems, situations in which legal measures to suppress satisfaction of a strong demand for goods or services breed a profitable and socially dangerous illicit market. Provided there is a strong enough demand, such repressive laws become patently unenforceable. This is largely a matter of simple economics, for as Robert Merton has noted: "In strictly economic terms there is no relevant difference between the provision of licit and of illicit goods and services."[7] If the demand is sufficient to support vast profits, means of making the supply available always will be found. For this reason I am strongly convinced that no narcotics policy that permits a large-scale demand for illicit drugs to persist can be expected to produce a major change in the over-all American addiction situation.

It is sometimes argued that legal provision of drugs would amount to perpetuation of disease or to giving up the effort to cure addiction. This argument ignores the fact that addiction is equally perpetuated under the present arrangements, even if doctors play no direct part in its perpetuation. As the late Hubert Howe stated, with regard to this Academy's 1955 proposal for a network of narcotics clinics across the country: "We are not saying to give the addicts more drugs, we are simply advising a different method of distribution. Every addict gets his drug right now. Why not let him have his minimum requirements under licensed medical supervision, rather than force him to get it by criminal activities through criminal channels."[8] One should also note in this connection the rather dismal results achieved in most efforts at cure under our existing policies, and what I believe to be a crucial consideration, that it simply may not be possible to cure an addict, in the long-term sense, against his will. Actually, the atmosphere under the nonpunitive British policy may well be more conducive to effecting real cures than that which exists in the United States, where we are so insistent that curing the addict be the main goal. Indeed, there are indications in this country, as reported, for example, by Nyswander[9] and by Freedman and his associates,[10] that treatment efforts are distinctly enhanced when the treatment atmosphere is nonpunitive and nonmoralizing. Compulsory commitment is compulsory whether it be to a prison or to an addiction treat-

ment center, and in neither case are the results likely to be very promising. This, it seems to me, may be one of several serious limitations of the new Civil Commitment Program, of which I expect you will hear more shortly.

Certainly, opportunities for voluntary admission to treatment, more and better treatment facilities, and more research are all desirable steps. But what is most vitally needed in this field, I believe, is an insistence by the medical profession (in this country as in Britain) on its right to decide what treatment addicted persons shall receive. Actually, there is some uncertainty as to whether it really is illegal in the United States for a doctor to prescribe narcotics for an addict in situations other than short-term withdrawal treatment. But the Treasury Department has, by regulation and in other ways, quite effectively curtailed efforts by individual practitioners to treat addicts on the basis of their considered medical determinations. As Karl Bowman stated several years ago: "A law which was designed as a revenue law (that is, the Harrison Act) has been pushed forward and extended, so that we have nonmedical persons telling doctors how to practice medicine and interfering with the legitimate and humanitarian care of sick persons."[11]

There is growing recognition in informed circles that a punitive approach to narcotic addiction simply will not work. I think that the Academy's Subcommittee was essentially correct in 1955 when it concluded that: "The most effective way to eliminate drug addiction (or, I would say, to attack the drug addiction problem) is to take the profit out of the illicit drug traffic."[12] The more recent report of the joint committee on narcotic drugs of the American Bar Association and the American Medical Association[6] illustrates strong professional dissatisfaction with current policy, and makes the important recommendation of an experimental outpatient clinic to test what would happen if addicts in this country were supplied with legal, low-cost drugs under controlled conditions. Let us hope that we are on the threshold of a new era in the treatment of the addict, an era characterized by a shift from punitive, cruel and ineffective policies to sensible and humane ones. In this connection, I feel, we have much to learn from the British. As Herbert Berger has stated, commenting on our repressive narcotics laws: "We at one time treated the leprous, the tubercular, the cancerous and the mentally diseased in this same fashion. One of the prides of our civilization is our recognition that

these people deserve our compassion, rather than our condemnation. Can we do less for our drug addicts?"[13]

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